



U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

Region VIII

FINAL REPORT

**Home and Community-Based Services Waiver Review
WYOMING ACQUIRED BRAIN INJURY Waiver Programs**

CONTROL NO. 0370.90.03

August 21, 2008

Executive Summary:

The Centers for Medicare and Medicaid Services (CMS) conducted a quality review of the Wyoming Acquired Brain Injury (ABI) Home and Community-Based Services (HCBS) waiver. This waiver serves adults age 21-64 that was approved from July 1, 2004 through June 30, 2009. The waiver is up for renewal with the waiver application due to the CMS Denver Regional Office no later than 90 days prior to the expiration, which is April 1, 2009. The CMS strongly recommends that the State submit the renewal through the web-based HCBS application process, which will save the State time and efforts in submitting future amendments and renewals.

According to the State, the mission of the Developmental Disabilities Division (DDD) is to provide funding and guidance responsive to the needs of people with developmental disabilities and ABI to live, work, enjoy, and learn in State communities with their families, friends, and chosen support services and support providers.

The waiver review was conducted by CMS in accordance with the Interim Procedural Guidance (IPG), which has been in effect for assessing HCBS programs since January 2004, with the latest revision effective February 2007. One of the main purposes of the IPG was to standardize the approach CMS utilized when assessing waiver programs as it transitions its quality oversight approach to one that incorporates both the assurance of statutory requirements and promotion of quality improvement.

Introduction:

Pursuant to section 1915(c) of the Social Security Act, the Secretary of the Department of Health and Human Services has the authority to waive certain Medicaid statutory requirements to enable a State to provide a broad array of home and community-based services (HCBS) as an alternative to institutionalization. The Centers for Medicare and Medicaid Services (CMS) has been delegated the responsibility and authority to approve State HCBS waiver programs.

CMS must assess each home and community based waiver program in order to determine that State assurances are met. This assessment also serves to inform CMS in its review of the State's request to renew the waiver. In accordance with federal regulations at 42 CFR 430.25(h)(3), the renewal request must be submitted to CMS at least 90 days before the currently approved waiver expires. The CMS strongly recommends that the State submit the renewal through the web-based 1915(c) HCBS application process, which will save the State time and efforts in submitting future amendments and renewals.

State's Waiver Name:	<u>Wyoming Acquired Brain Injury Waiver</u>
Administrative Agency:	<u>Wyoming Department of Health, Office of Health Care Financing</u>
Operating Agency:	<u>Developmental Disabilities Division</u>
State Waiver Contact:	<u>Beverly Swistowicz, Waiver Manager</u>
Target Population:	<u>Adults Age 21-65 with Acquired Brain Injury</u>

Level of Care: Intermediate Care Facility for Persons With Mental Retardation and Related Conditions (ICF/MR)

Number of Waiver Participants: Current Waiver Year 4, effective 7/1/07-6/30/08, the State was approved to serve 175 unduplicated recipients for waiver years 3-5.

Average Per Capita Waiver Costs: Waiver Years 4-5, the annual estimated average cost per person was approved at \$37,291.

Effective Dates of Waiver: July 1, 2004 – June 30, 2009

Approved Waiver Services: Case Management, Personal Care, Respite Care, Habilitation (including residential habilitation day habilitation, prevocational services, supported employment and in home support), Environmental Accessibility Adaptations, Skilled Nursing, Specialized Medical Equipment and Supplies, Extended State Plan Services (including physical therapy, occupational therapy, speech, hearing and language), Cognitive Retraining, and Dietician Services.

CMS Contact: Eunice Perez, Health Insurance Specialist Denver Regional Office

I. State Conducts Level of Care Need Determinations Consistent with the Need for Institutionalization

The State must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care need consistent with care provided in a hospital, NF, or ICF/MR.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.5

CMS Finding: The State substantially met this assurance.

Evidence Supporting this Conclusion:

The Developmental Disabilities Division (DDD) determines eligibility for the ABI after application and assignment of a case manager. Medical documentation is required and reviewed by a physician and registered nurse. Once medical documentation is verified, the case manager assists the applicant in scheduling a neuropsychological evaluation. After the neuropsychological evaluation is completed, a functional assessment is completed. The Inventory of Client and Agency Planning (ICAP) is administered by an independent contractor, Wyoming Institute for Disabilities (WIND).

Once eligibility is determined the Division uses a LT-ABI-105 form to determine level of care (LOC). This form verifies that the ABI applicant meets an intermediate care facility for persons with mental retardation and related conditions (ICF/MR) level of care. These forms are completed by the case manager, with information on the diagnosis and level of support and supervision taken from the neuropsychological evaluation, medical documentation, and the ICAP. These forms are also completed within a year of the last LOC screening date and prior to submitting the annual service plan to the Division for approval.

The State provided information on the processes and monitoring activities related to this waiver, and also submitted the required evidence and its own Remediation/Action Plan in which to address State-identified issues. The following evidence and Remediation/Action Plans were submitted by the State that demonstrated compliance with this assurance:

Evidence:

Subassurance: An evaluation for level of care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.

1. 122 people applied for the Acquired Brain Injury Waiver in Fiscal Years 2006 and 2007.
2. 19% (23) of applicants did not complete the eligibility process for the waiver.
3. Of the 81% (99) that completed the eligibility process, 24% (23) were found not eligible. These individuals were notified through an Adverse Action/Denial of Eligibility letter, which included information on the right to a Fair Hearing.
 - A. 12 were not medically eligible

- B. 6 were not clinically eligible
- C. 5 were not financially eligible
- 4. Of the 81% (99) that completed the eligibility process, 76% (71) were found eligible.
 - A. 56 are receiving waiver services
 - B. 8 chose not to receive services
 - C. 7 are on the waiting list
- 5. There are still 6 individuals who are working through the eligibility process and are pending.
- 6. Before the service plan was submitted to the Division for approval, 100% (56) level of care (LT-ABI-105) forms were completed for each applicant receiving a funding opportunity by his/her chosen case manager.
 - A. If an error was found on the LT-ABI-105 form, the Waiver Specialist contacted the case manager for corrections.
 - B. No waiver funding was made available to a participant through an approved service plan until the level of care form was approved by the Waiver Specialist, which assured the person met the level of care needed to qualify for waiver services.
 - C. No plans were approved without a complete level of care determination.

Wyoming Remediation/Action Plan

To explain a gap identified in the system, referring to Evidence items 2 and 5 above, Division staff discussed the number of applicants who did not complete the eligibility process in Fiscal Year 2006 and 2007 for the Acquired Brain Injury Waiver. Staff noted that applicants usually have various reasons for not completing the process, such as memory problems as a result of the brain injury, transient living, not choosing a case manager, changing their minds, etc. However, the Division does not have a system in place to determine whether a person has not progressed in the eligibility process in two months or more. Therefore, no Division staff routinely followed up on an applicant unless he/she resurfaced through a phone call to the Division, a crisis, or by word of mouth from a provider or concerned citizen.

To help improve the Division's follow up on applicants to assist them in getting needed services, Division staff proposed developing a tickler system in an electronic application database. The system would track dates of application and dates of choosing the case manager, and if more than two months go by with no further action, then a reminder for follow up would be sent to the Area Resource Specialist. The electronic application system will be web-based and implemented at approximately the same time as the electronic plan of care, which the proposed timeline for implementation is January 2010.

In reference to Evidence item 6, no service plans were approved without qualifying clinical eligibility documentation, financial eligibility, and a complete level of care determination, but the Division did not collect data on the number of level of care forms that were incorrect and returned to the case manager. Beginning July 1, 2008 Waiver Specialists will track the number of level of care determination forms that need to be corrected by the case manager. If a trend is identified, where many forms need corrections by a certain case management organization, then follow up consultation will

be made by the waiver staff to resolve the problem and offer training on the form to the organization.

Evidence:

Subassurance: An evaluation for enrolled participants is reevaluated at least annually or as specified in the approved waiver.

1. In Fiscal Year 2007, 100% (147) Acquired Brain Injury Waiver participants had LT-ABI-105 forms (Level of Care) completed by the case manager before the submission of the annual service plan.
2. 100% (147) annual service plans, which included the Level of Care determination form, were reviewed by a Waiver Specialist at the Developmental Disabilities Division before the service plan was approved.
 - A. If the form was incorrect, then the Waiver Specialist contacted the case manager for corrections.
 - B. The form was then resubmitted to the Division before the plan was approved.
 - C. No plans were approved without a complete level of care determination.

Wyoming Remediation/Action Plan:

Although no plans were approved without a complete level of care determination, the Division did not collect data on the number of forms that were returned to the case manager. Beginning July 1, 2008 Waiver Specialists will track the number of level of care determination forms that need to be corrected by the case manager. If a trend is noticed, where many forms need corrections by a certain case management organization, then follow up consultation will be made by the waiver staff to resolve the problem and offer training on the form to the organization.

Evidence:

Subassurance: The process and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

1. 100% (147) of Acquired Brain Injury Waiver service plans were reviewed for the following eligibility requirements, as required the Wyoming Acquired Brain Injury Waiver:
 - A. Neuropsychological evaluation
 - B. ICAP
 - C. Financial eligibility as reported in MMIS
 - D. LT-ABI-105
2. Two individuals no longer met eligibility during the 2007 fiscal year.
 - A. One plan of care submitted for approval had a new neuropsychological evaluation that showed that the participant no longer met the clinical criteria, so the participant no longer eligible for waiver services. The Acquired Brain Injury Waiver Manager followed the loss of eligibility rule and process in the Wyoming

Medicaid Rules Chapter 43. The individual received an Adverse Action/Denial of Eligibility letter, which included information on the right to a Fair Hearing.

- B. In addition, the Department of Family Services determined that one participant no longer met financial eligibility. The family received notification from that Department which included the right to a Fair Hearing. Waiver services were no longer available to that participant and the case manager ended the plan of care.

Wyoming Remediation/Action Plan:

The monitoring process will continue with no action plan to change at this time.

CMS Recommendation:

As part of the State's processes to determine eligibility, the level of care determination via the Wyoming LT-ABI-105 form is a critical step. This is a step the State is currently waiting to complete until after the person has been put on the waiting list and funding becomes available. CMS recommends ensuring the LT-ABI-105 form is completed earlier on in the process, such as around the same time the neuropsychological evaluation is conducted, and before time and money is spent on completing the ICAP.

State Response:

The Division will take this recommendation under advisement as we work on the waiver renewal. Information from the ICAP helps verify the functional limitations of the individual which is part of the LT-ABI-105 Level of Care determination. Since the ICAP is one of the 4 qualifying evaluations for eligibility on the ABI waiver, we have been advised by our Attorney General's office to administer this evaluation before determining eligibility. The implementation of this recommendation would require a change in Wyoming Medicaid Rule, Chapter 43 that states the LT-ABI-105 is completed after the ICAP is received.

Final Federal Response:

The State's response to this recommendation is acceptable. CMS commends the State for its efforts for improving the Divisions follow-up actions by developing a tickler system in an electronic application database to assist applicants in getting needed services.

II. Service Plans are Responsive to Waiver Participant Needs

The State must demonstrate that it has designed and implemented an adequate system for reviewing the adequacy of plans of care for waiver participants.

Authority: 42 CFR 441.301; 42 CFR 441.302; 42 CFR 441.303; SMM 4442.6; SMM 4442.7; Section 1915(c) Waiver Format, Item Number 13

CMS Finding: The State substantially met this assurance.

Evidence Supporting Conclusion:

The State provided information on the processes and monitoring activities related to this assurance. The Service Plan also called the Individual Plan of Care or IPC, serves as the authorization for waiver services for a participant on the waiver. Providers cannot provide and bill for services until they have been selected by a participant and until the plan of care has been approved by the Developmental Disabilities Division. The plan of care normally covers a period of one year. Although there are situations when the plan may cover less than a year, a plan never will exceed a year. Once the plan of care is finalized, providers will receive a copy. It is a provider's responsibility to understand the services and supports outlined in the plan of care. Included in the plan is the pre-approval page. This page details the exact type and amount of services that the participant is authorized to receive from a provider.

The process used in determining services for the Acquired Brain Injury Waiver uses a person-centered approach to assure the personal goals and interests of the participant are included in the planning the services. The case manager must thoroughly identify the participant's demographics, waiver and non-waiver service needs, medical information, and ongoing health and safety concerns. The plan also requires a description of the participant's supervision and support needs in various areas, places and times, based on the neuropsychological report, ICAP and medical information. If the participant has maladaptive behaviors identified in the assessments or in the plan, then a positive behavior support plan is required. Objectives and schedules are required for each habilitation service on the plan and must reflect the health, safety, goals and interests of the participant.

As indicated in the previous section, the State submitted the required evidence and a remediation/action plan to address identified issues. The following evidence and remediation/action plan demonstrates compliance with this assurance.

Evidence:

Subassurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.

1. In Fiscal Year 2007, 100% (147) of service plans for each waiver participant were reviewed by a Waiver Specialist to assure:
 - A. The service plan addressed the supervision and support needs of the participant based on information from the neuropsychological evaluation, ICAP, other assessments if included, and medical, health and safety concerns listed.
 - B. The "About Me" section questions were answered with participant and/or guardian input and reflected the participant's goals, likes, dislikes, interests, hobbies, and natural supports.
 - C. The objectives and schedules reflected the personal goals, interests, health and safety information listed elsewhere in the plan.
 - D. Services on the plan, both waiver and non-waiver, were appropriate for the participant's needs.

- E. A positive behavior support plan was included when maladaptive behaviors were identified in the assessments or elsewhere in the service plan.

Wyoming Remediation/Action Plan:

After the rules were promulgated in December 2006, the case managers and Division staff were required to work in compliance with the new rules. This impacted the service plan approval system and required a new collaboration with the Division and case managers to learn the rules, use the new provider manual for additional guidance, and build service plans with more detail and cohesiveness than previously required.

Waiver Specialists worked diligently on reviewing service plans in accordance with the rules, but case managers were not fully knowledgeable of the rules and did not submit plans that were fully in compliance. Therefore, to build the collaborative and consultative relationship with providers, Division staff tried to educate case managers and other providers to correct problem areas of the plan by phone consultation, comment pages, and through Division trainings. After all areas of concern were addressed, plans were approved without disrupting services for the participant.

In January 2007, the ABI Waiver staff began using a database to track the plans which required a comment page to be sent. However, the categories of problems identified were not quantified. Beginning in July 2008, Wyoming will collect categories of problems that require correction before the plan can be approved. By gathering this information and analyzing it quarterly, the Division can schedule training for providers in general or organization-specific when trends are noticed.

In asking Waiver Specialists to list the most problematic areas, they all responded to the same key areas, which were positive behavior support plans, objectives, and rights restrictions.

In identifying the key problematic areas of the plan, the Division formed working groups with various stakeholders in November 2007 to discuss the rules, plan guidelines and forms to make clear expectations to those areas of the service plan. In working on these areas with stakeholders and Division staff, Division managers were able to finalize policy and procedures and revise the service plan instructions to be more consistent, compliant, and streamlined across all three Medicaid waivers at the Division.

The Division updated the service plan forms to correspond with the new expectations and requirements the Division implemented based on input from the working groups. The new service plan was introduced in two April 2008 Provider trainings and will be required for all plans as they come due after June 30, 2008.

Other enhancements to the service plan will be implemented when the Division switches to an electronic plan of care, currently under development and scheduled to be implemented in January 2010. One area or gap the Division plans to address with the electronic plan is to assess more non-waiver supports and services used or available to the participant. Currently, the service plan has the case manager mark a box if non-waiver services are used. Standard non-waiver services are listed, such as SSI, SSDI, Food

stamps, and Housing, and the service used is underlined. Although a few extra boxes are available to be marked for services not listed, rarely are other services described or marked. The electronic plan is also going to assess and capture information in other gaps we have identified such as participant risks, natural supports, and structure for developing a positive behavior support plan and objectives.

In some cases, when the service plan does not fully address a health, safety or medical need of the participant, the Division will make a referral to APS Healthcare. This organization will investigate and advise a participant's team on extraordinary circumstances, health and safety concerns, complaints, or other protocols to explore in serving a person in a community-setting.

Evidence:

Subassurance: State monitors service plan development in accordance with its policies and procedures.

1. Area Resource Specialists attended 44% (150) of all Acquired Brain Injury Waiver team meetings for fiscal year 2007.
2. There were 2 internal referrals from Area Resource Specialists regarding ABI Waiver providers. 1 concerned health and safety and 1 concerned the quality of services provided.
 - A. 100% (2) providers were required to submit a quality improvement plan addressing the non-compliance.
 - B. The Survey/Certification unit of the Division monitored implementation of all of the quality improvement plans to assure that the providers addressed the non-compliance appropriately.

Wyoming Remediation/Action Plan:

The Division held an all staff meeting in July 2007, so staff in the different units of the Division could identify gaps in the system, including service plan development and plan approval. Information on gaps identified at this meeting and comments made by case managers and providers during site surveys resulted in many items needing to be addressed. Primarily, the expectations of the waiver specialists in approving plans did not coincide with how service plans were developed by the participant's team and case manager.

One approach to help narrow the gap between how a plan is developed and how it is approved by Division staff was to revise the plan guidelines, or instructions, that are available to providers as a tool in plan development. The guidelines being used were developed before the rules were promulgated in December 2006, so they were not fully encompassing all of expectations set forth in the rules. Therefore, the plans submitted to the Division had gaps in them.

In November 2007, the Division created working groups involving providers, case managers and various waiver staff from different units to address key problematic areas of the plan of care to come to a consensus on certain items and develop more specific criteria

and instructions in other areas to make the plan easier to develop in accordance with the rules.

In March 2008, the revisions to the service plan instructions were made, distributed to providers, and posted to the Division's website. Provider training on the changes and service plan expectations was facilitated by the Waiver Managers to inform them about the changes, expectations, and tools available. Training was completed in April 2008 through video conferencing and DVDs of the trainings were made available to providers who could not attend the training. Also, to assist providers with developing positive behavior support plans, objectives, and discussing right restrictions with participants and families, the Division has developed tools to post on its website, which offer prompts for discussion, key areas to address, and sample formats to use.

The Division has scheduled additional regional trainings for spring and summer 2008 to address gap areas in plan development. Topics include: team meetings, transitions, and IPC instructions. In addition, the Division has contracted with a psychologist to conduct regional trainings in summer 2008 on writing positive behavior support plans and performing a functional analysis for a behavior plan.

Evidence:

Subassurance: Service plans are updated or revised at least annually or when warranted by changes in the waiver participant's needs.

1. 100% (147) of service plans were reviewed by a Waiver Specialist to assure the participants needs and wishes are addressed as fully as possible and the plan complies with the rules.
2. 100% of all modifications submitted to the Division are reviewed by the Waiver Specialist, although not all of them are approved. Reasons for not approving a modification to the service plan included:
 - A. A modification that did not meet the participant's health, safety, or medical needs, or
 - B. A modification that included a non-certified service provider, or
 - C. The modification amount exceeded the Individually Budgeted Amount (IBA) for the participant, then:
 - I. The modification went to ECC to seek approval for additional funding, or
 - II. The modification was withdrawn by the case manager.
3. Of the 147 of ABI Waiver plans approved by the Division in fiscal year 2007, 6% (9) used the ECC process to approve funds above the IBA to meet service needs for the participant.
 - A. 2% (4) of all 147 ABI waiver participants received some additional funding in fiscal year 2007 as a result of the ECC process. One of these cases required follow-up monitoring as requested by the Acquired Brain Injury Waiver Manager. However, the participant left the state before the requested follow-up was completed. That participant is no longer receiving waiver services.

Wyoming Remediation/Action Plan:

While providers are learning the new rules and expectations required in the service plan, the Waiver Specialist and Manager have also been consulting on an individual basis with case managers.

Through the provider recertification process and the complaint process, the Division continues to identify concerns with lack of documentation or insufficient documentation by case managers' specifying how they are monitoring the implementation of plans of care, completing follow-up on concerns found with implementation, and making changes to the plan as needed. The Survey/Certification Unit of the Division is in the process of revising the case managers' monthly quarterly documentation tool to provide more clear guidelines on the specific type of monitoring and documentation case managers are required to complete. This tool will be completed and distributed by July 1, 2008 and re-education of case managers on the requirements for monitoring implementation of plans of care and completing follow-up on concerns or changes needed to the plans will be completed by September 2008.

Evidence:

Subassurance: Services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

1. In fiscal year 2007, Area Resource Specialists attended approximately 44% (150) of annual, six month, or other team meetings for participants on the Acquired Brain Injury Waiver, providing guidance and education.
2. The Survey/Certification Unit of the Division completed annual recertification of 100% of the certified Acquired Brain Injury Waiver providers (484) in fiscal year 2007, including, when appropriate, review of implementation of plans of care for participants. The Division does not currently track recertification by type of waiver. The following data is from all providers recertified by the Division.
 - A. 5% of the Waiver providers received recommendations during their recertification due to concerns with implementation of the plans of care
 - I. 21% of CARF organizations received at least one recommendation identifying concerns with the implementation of plans of care.
 - II. 4% of non-CARF providers received at least one recommendation identifying concerns with the implementation of plans of care.
 - a. 100% of the providers, who received a recommendation in this area, were required to submit a quality improvement plan to address the concerns with the implementation of the plans of care.
 - b. The Survey/Certification Unit completed follow-up monitoring on 100% of the cases to assure the concerns were addressed.
 - B. 2% received recommendations identifying concerns with case managers' documentation and follow-up on concerns in the monthly/quarterly reporting requirements.
 - I. 21% of CARF organizations received at least one recommendation identifying concerns with their monthly/quarterly documentation.

- II. 1% of Non-CARF providers received at least one recommendation identifying concerns with their monthly/quarterly documentation.
 - a. 100% of these providers were required to submit a quality improvement plan to address the concerns with their documentation.
 - b. The Survey/Certification Unit completed follow-up monitoring on 100% of the providers to assure the concerns were addressed.
3. The Survey/Certification Unit received 7 complaints involving participants on the Acquired Brain Injury Waiver in fiscal year 2007. *Review of all complaint statistics can be found under the Evidence in the Qualified Providers section of this evidentiary report.*
 - A. None of the complaints indicated case management non-compliance with rules and regulations, including concerns with monitoring implementation of the plan of care.
4. Through the National Core Indicator project, 25 Acquired Brain Injury Waiver participants were interviewed in 2006-2007 for the consumer survey. ABI programs in other states do not participate in Core Indicators so there is no national data to compare.
 - A. 100% of participants state that they know their service coordinator.
 - B. 84% of participants state that their service coordinator asks them about their preferences.
 - C. 100% of participants interviewed stated that they were satisfied with their work or day programs.
 - D. 100% of participants stated they were satisfied with their home.

Wyoming Remediation/Action Plan:

In early 2006, the Division identified concerns with case managers' documentation of monitoring the implementation of plans of care. While documentation was being completed, it was often not specifically identifying concerns or follow-up actions taken to address concerns. This was most notably identified in the area of case management review of utilization of services for each participant, and health/safety changes such as weight loss or gain, changes in seizure activity etc.

Effective July 1, 2006 the Division revised the monthly/quarterly requirements and sample form to more specifically include this information. While completing monitoring duties the Survey/Certification Unit has identified improvements in this area and the number of recommendations specific to case management documentation is decreasing. The result is that case managers are more thoroughly documenting the results of their review of the implementation of the plan of care and, when concerns are found, what follow-up actions are completed to address the concerns and whether these follow-up actions addressed the concerns.

However, through the provider recertification process and the complaint process the Division continues to identify concerns with lack of documentation or insufficient documentation by case managers' specifying how they are monitoring the implementation of plans of care, completing follow-up on concerns found with implementation, and making changes to the plan as needed. The Survey/Certification Unit of the Division is in the process of revising the case managers' monthly quarterly documentation tool to provide more clear guidelines on the specific type of monitoring and documentation case

managers are required to complete. This tool will be completed and distributed by July 1, 2008 and re-education of case managers on the requirements for monitoring implementation of plans of care and completing follow-up on concerns or changes needed to the plans will be completed by September 2008.

The Area Resource Specialists continue to provide education and feedback during the plan of care meetings, and they are identifying significantly fewer concerns with review of implementation of plans of care. Team meeting notes are completed after each team meeting the ARS attends. These notes are shared with Waiver Managers, Waiver Specialists and Survey/Certification staff. Monthly data collected, indicates that choice was/wasn't offered, that fiscal concerns were discussed and health and safety issues were discussed and resolved. Monthly data from team meeting notes also reflects any provider compliance issues.

The Division does not review data collection to ensure quantifying data accurately reflects the percent of providers who received recommendations on training. The Division is working with the Wyoming Department of Health Information and Technology (IT) Division to restructure our database so it is more streamlined and easier to extract data.

Based on the collaboration, the Division is working with IT to develop a Comprehensive Provider Management System that will streamline both the tracking of individual monitoring activities and aggregating and analyzing data by waivers, by provider, by categories, and by priority levels.

The timeline for the system is as follows:

- Proposal for system completed by January 2008
- Contract finalized in February 2008
- First components of system developed and tested by April 2008
- Second major components of system developed and tested by June 2008
- Final major components of system developed and tested by August 2008
- First reports generated by October 2008.

During this development process Survey/Certification staff will continue to track data in the current databases.

The National Core Indicator project only sampled 25 participants referring to Evidence item 4 above. The Division realizes this is a very small sample and will be reviewing the methodology and sample size. A decision will be made by December 2008 identifying the minimal sample size and if the interviews will only take place every other year.

Evidence:

Subassurance: Participants are afforded choice: 1) between waiver services & institutional care; and 2) between/among waiver services and providers.

1. 28% (353) of all team meetings on all three waivers attended by Area Resource Specialists were transition meetings. The transition process verified that participants and families were offered choice and exercised their right to change providers.

2. 100% (147) of all ABI plans approved in fiscal year 2007 have a “Notice of Choice” form signed by the participant and/or guardian verifying that choice of provider had been given.

Wyoming Remediation/Action Plan:

Although data is collected on the number of transition meetings attended, it is not collected by waiver type referring to Evidence item 1 above. Beginning July 2008, the number specific to each waiver will be collected. Non-compliance with the transition requirements increases the health and safety risks of participants as they move from one location to another or one service provider to another. Therefore, the Division will review the data to determine if a case manager is failing to comply with the transition rules. If this is found, the Survey/Certification Unit will require the provider to submit a quality improvement plan and will monitor the provider’s compliance with the plan.

Recently, Area Resource Specialists started collecting data at team meetings regarding a participant or guardian’s response in verifying that choice was offered. Beginning July 2008, this data will be collected per waiver. The Division will review the data to look for trends to determine if a specific provider is not routinely offering choice. If this trend is found the provider will be required to submit a quality improvement plan specifying how they are going to comply with the requirement to offer choice. The Survey/Certification Unit of the Division will monitor the provider’s compliance with the quality improvement plan.

CMS Recommendations:

1. In regard to the changes being made in collaboration with the Department of Health Information and Technology (IT), please provide more detail as to what these changes will do relative to the Quality Improvement Strategy, and what the State plans to do with the information generated from these reports.
2. Please include the IT changes in the CMS-372 reports under the Quality Section.
3. Please ensure when providing future evidence that the source of the information for service plans is generated at the individual level, not the provider level. How is the State monitoring any impact on the individuals and ensuring any correction at the provider level translates to better service planning and implementation for the individual?

State Response:

1. The Division currently collects data from monitoring activities in a variety of databases that are not linked or automated. Compilation and analysis of the data is cumbersome, labor intensive, and it is difficult to identify trends across monitoring activities. The web-based system being developed in collaboration with the Department of Health Information and Technology will allow the Division to collect, track and analyze the data across monitoring activities in a more reliable, timelier, and more efficient manner. Trends will be able to be identified more quickly, and tracking of non-compliance will be easier to manage. Therefore, while the data and information collected will not change drastically, the ability to

access, analyze and respond to trends identified will be significantly improved. The majority of the data currently collected was reported in this Evidentiary Report, and will continue to be used to provide evidence that the state is meeting the CMS assurances.

2. The Division will include IT changes in the CMS-372 lag report for Year 3, 2006-2007. This report will be sent to CMS no later than December 31, 2008.
3. 100% of all plans are reviewed by waiver specialists. The state will continue this practice to assure that plans are meeting individual needs. The information generated at the provider level will provide comparison data to evaluate if recommendations in this area are decreasing. The Area Resource Specialist participation in meetings can be targeted to a specific organization if that data supports more intense supervision at team meetings.

During the provider certification process a random sample of participants are chosen to review the implementation of their plans of care. This review includes a provider documentation review including documentation the implementation of the plan of care. While the Division is able to track the resolution of concerns that are found during this process, there is a gap in our data collection because we are not able to aggregate the data as a result of these reviews. This is being addressed with the Dept of Health IT provider management system being developed. Upon completion of that system not only will the Division be able to assure that participant specific concerns are addressed but will also be able aggregate and analyze the results of the monitoring to identify trends specific to waivers and to providers.

Final Federal Response:

1. Please ensure there is a formal quality improvement strategy in place at the time of the renewal with a system in place to comply with all requirements in the plan of care assurance. CMS commends the State in developing a web-based system that will allow the Division to collect, track, and analyze data across monitoring activities in a more reliable, timely and efficient manner.
2. The State's response to this recommendation is acceptable.
3. Please continue to work with the Department of Health IT in resolving the State's data collection issue to ensure that participant specific concerns are addressed and the State can aggregate and analyze results of monitoring to identify trends specific to waivers and providers.

III. Qualified Providers Serve Waiver Participants

The State must demonstrate that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Authority: 42 CFR 441.302; SMM 4442.4

CMS Finding: The State substantially met this assurance.

Evidence Supporting Conclusion:

The State submitted the required evidence and its own remediation/action plan to address identified issues as follows.

Evidence:

Subassurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services.

1. 66 new providers were certified for Acquired Brain Injury Waiver services during fiscal year 2007. 100% of the providers met the qualifications for services and completed the Waiver Provider Manual training
2. 100% of 484 providers certified to provide Acquired Brain Injury services were recertified during fiscal year 2007. The Division does not currently track recertification recommendation by type of waiver. The following data is from the recertification of all providers certified by the Division.
 - A. 53% of non-CARF providers received at least one recommendation that required submission of a quality improvement plan
 - I. The most common recommendations made for Non-CARF providers were to address non-compliance with required policies and procedures, drills/inspections, and with incident reporting requirements
 - B. 100% of CARF providers received at least one recommendation that required submission of a quality improvement plan
 - I. The most common recommendations made for CARF organizations were to address non-compliance with environmental concerns, incident reporting, and drills/ inspections
 - C. 100% of all quality improvement plans were monitored for compliance by the Survey/Certification Unit of the Division to assure that the areas of non-compliance were addressed appropriately.
3. The Division suspended 5 providers certified to provide Acquired Brain Injury services during fiscal year 2007.
 - A. 2 suspensions were due to non-compliance with rules that impacted health and safety and resulted in reinstatement of certification once concerns were addressed.
 - B. 1 suspension was due to charges of assault and resulted in decertification.
 - C. 2 suspensions were due to substantiation of abuse/neglect from Department of Family Services and resulted in decertification.
4. 5% (7) of the complaints received concerned Acquired Brain Injury Waiver services
 - A. The Survey/Certification Unit categorized and investigated 100% of the complaints.
 - I. 4 involved service quality.
 - II. 2 involved provider or case management compliance with rules/regulations.
 - III. 1 identified possible rights restrictions.
 - IV. 0 were Level 1 complaints that resulted in on-site visits.

- V. 0 involved billing/documentation concerns.
- VI. 0 identified potential health and safety concerns.
- VII. 0 were filed as Division system-wide concerns.
- VIII. 0 identified concerns with confidentiality.
- B. The Division completes follow up monitoring on 100% of the complaints that have been substantiated.
 - I. For the ABI Waiver, 1 complaint concerning provider compliance was substantiated, resulting in the provider submitting a quality improvement plan to address the areas of non-compliance.
 - II. The Survey/Certification Unit monitored implementation of the quality improvement plan to assure the concerns were addressed.
- 5. The Area Resource Specialists completed 2 referrals to the Survey/Certification Unit due to concerns with ABI Waiver provider compliance
 - A. 1 of the referrals (50%) identified concerns with health and safety
 - B. 1 of the referrals (50%) identified concerns with quality of services
- 6. One of seven deaths (14%) that occurred between July 1, 2006 and December 31, 2006 was a participant on the ABI waiver
 - A. No significant concerns were found with the services provided but one provider specific recommendation was made related to documentation concerns. The provider was required to submit a quality improvement plan and the Survey/Certification Unit of the Division monitored compliance with the plan.

Wyoming Remediation/Action Plan:

The Division promulgated rules in December 2006, including rules that specified provider requirements, certification and recertification requirements, and sanctioning authority. The rules include specific policies, procedures and processes that Non-CARF providers are required to develop. Throughout the rest of fiscal year 2007 Program Integrity staff worked with Non-CARF providers to assist them in developing these policies and procedures. In addition to the one-on-one assistance given to Non-CARF providers by Division staff, the Division has also developed sample policies and procedures for providers to reference. The most recent data indicates that the percentage of recommendations addressing non-compliance with policies and procedures is decreasing. A formal measure of this information will be completed in July 2008.

Provider and provider staff knowledge of the incident reporting requirements continues to be a major concern. As of August 2007 the Division began requiring providers to receive training on incident reporting from the Division when significant concerns with adhering to the incident reporting requirements were found. As of January 2008 three trainings have been completed. In addition, the Division has completed a module on incident report training and will be distributing the module on DVD by March 30, 2008. The Division has also scheduled regional trainings on incident reporting for calendar year 2008. All providers are required to attend the regional training, review the training module on DVD or develop their own training that covers all the requirements included in the Division's trainings. The Division monitors compliance with this requirement during the provider recertification process.

The Division will continue to collect and analyze data on incident reporting requirements to determine if these action steps are addressing the concerns.

The Division continues to work with providers on the billing and documentation requirements. Effective January 2006, the Division began a formal process of reviewing documentation standards with providers and providers became required to sign a copy of the current documentation standards after this review. Division staff continues to educate providers on the requirements when concerns are found during recertifications or complaints. The Division has also strengthened the process of referring cases to the Office of Healthcare Financing (Medicaid) for possible recovery of funds. Improvements in this process included developing a referral cover sheet requiring Survey/Certification staff to submit specific information on the referral to Medicaid, requiring Survey/Certification staff to submit copies of the signed documentation standards and documentation of education completed with the provider prior to the recovery with the referral so it is clear that the provider had been trained on the documentation standards, and requiring that Medicaid provide the Division a copy of the recovery letter so the Division can assure the recovery has been completed. Current data being collected indicates that the percentage of concerns with billing and documentation are decreasing, but the data will be formally analyzed in July 2008 to determine if this trend continues.

The Division currently has a system monitoring process for this assurance, but is in the processing of enhancing data collection, tracking and analysis to assure that data is valid and reliable and to improve staff efficiency.

Evidence:

Subassurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

- Wyoming does not allow non-certified providers to provide any services under the Acquired Brain Injury Waiver.

Evidence:

Subassurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

1. During the time period of July 2006 through June 2007, the Division provided various training topics to participants, families, guardians, providers, outside agencies, and the Division's advisory board.
2. Training flyers and listserv emails were sent to the previously mentioned entities describing the training sessions.
3. Listed on the following chart are the training sessions conducted by various DDD staff:

Name of Training	Type of Media	Audience	Division Staff	# of sessions
Beginning ISC	Video Conference	Case Managers	Waiver Specialists	1
DDD Rules & Provider Manual	Video Conference	All Providers	All DDD Managers	2
Transition Meetings	1:1 or small group	Case Managers	Area Resource Specialists	20
Team Meetings	1:1 or small group	Case Managers, schools, other state agencies	Area Resource Specialists	18
Application Process	Small group	Case Managers	Area Resource Specialist	3
*Initial Provider Training	In person or by phone conference	All new providers	Survey/Certification	130

4. No provider applicant received their provider ID enrollment number until they completed the Initial Provider training and signed a form stating as such.
5. There were 130 new providers certified who received the training on the provider manual from July 1, 2006 through June 30, 2007.
6. Quality Improvement Surveys of providers showed:
 - 43% of the CARF organizations recertified had a recommendation on staff training.
 - 32% of the Non-CARF organizations recertified had a recommendation on provider/staff training.

Wyoming Remediation/Action Plan:

Survey/Certification staff enters the provider training recommendations into an Access database. This information is reviewed quarterly by management and Survey/Certification staff to identify any trends. Both positive and negative trends are identified. The positive trends are reviewed to determine the impact of remediation actions the Division has taken in specific areas and to identify the strengths within our system. The negative trends are reviewed to identify appropriate action steps to take to address the trends. The management staff then agrees on methods to create change if the trends are of a negative nature.

The information derived from the database is shared with stakeholders to review and make suggestions for change. Stakeholders include the DDD Advisory Council, providers, participants and families. Through sharing the information on trends and areas of concern, the Division seeks to resolve the matters through forming working groups, developing new tools or guidance for provider or Division staff, or gathering input for making a system change in the new waiver application.

Training modules to accommodate providers for rule requirements are not fully completed. To address this issue, the Division will continue to develop and publish

training DVDs to offer to providers in order for them to meet Chapter 45 rule requirements. The Division will also provide regional training across the state as another avenue for providers to meet Chapter 45 rule requirements. The training DVD modules will be completed by December of 2008. Regional trainings are scheduled monthly through October 2008. Although attendance is not mandatory for the regional training, a provider is required by rule, to receive training as listed in Chapter 45. This can be accomplished by watching the DVD, then writing a summary of the module, and placing it in their file. The Survey/Certification Unit will review these at the time of recertification.

The Division will continue to provide training for all new providers. We will also complete training DVDs and regional training on specific information that is required by Chapter 45 of the Division rules. Our website will include a yearly calendar of upcoming training sessions.

The Division does not review data collection to ensure quantifying data accurately reflects the percent of providers who received recommendations on training. The Division is working with the Wyoming Department of Health Information and Technology (IT) Division to restructure our database so it is more streamlined and easier to extract data.

Based on the collaboration, the Division is working with IT to develop a Comprehensive Provider Management System that will streamline both the tracking of individual monitoring activities and aggregating and analyzing data by waivers, by provider, by categories, and by priority levels.

The timeline for the system is as follows:

- Proposal for system completed by January 2008
- Contract finalized in February 2008
- First components of system developed and tested by April 2008
- Second major components of system developed and tested by June 2008
- Final major components of system developed and tested by August 2008
- First reports generated by October 2008.

During this development process Survey/Certification staff will continue to track data in the current databases.

CMS Recommendations:

1. In reference to the Division scheduling regional trainings on incident reporting and the requirement that all providers are required to attend the training, review the module on DVD, or develop their own training, does the State monitor/approve the training material providers use prior to the provider doing their own training?
2. Please include the changes noted above in the Quality Section of the CMS-372 reports.

State Response:

1. For those providers who choose to develop their own training, the State reviews the training material at the annual site review to assure that the key components of the area of training are being covered. If concerns with the training material are found, then the provider receives a recommendation to assure that the training includes all appropriate components. The provider is required to submit a quality improvement plan on how this recommendation will be addressed. To date, the Division has not made recommendations specific to the training modules developed, but if a recommendation is made then the Division will complete follow-up monitoring to assure the areas of non-compliance are addressed.
2. The Division will include changes on provider training in the CMS-372 lag report for Year 3, 2006-2007. This report will be submitted to CMS no later than December 31, 2008.

Final Federal Response:

The State's response to the recommendations in this assurance is acceptable.

IV. Health and Welfare of Waiver Participants

The State must demonstrate that, on an ongoing basis, it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

Authority: 42 CFR 441.302; 42 CFR 441.303; SMM 4442.4; SMM 4442.9

CMS Finding: The State substantially met this assurance, but additional information is requested.

Evidence Supporting this Conclusion:

The State provided the following additional information in assuring that the health and welfare of participants is achieved through many processes on many levels of the service delivery system in Wyoming.

The plan of care includes sections on rights and rights restrictions, and other health and safety information to assure that the participant is receiving the appropriate level of support while maintaining as much independence as possible. The plan of care also includes an "About Me" section where the team, with the participant identifies significant events and achievements that occurred over the past year

Team meeting guidelines are in place to assist case managers through the team meeting process. The guidelines include a review of incidents and other health and safety concerns that need to be addressed in the plan of care.

Case managers complete a monthly home visit and observe services for each participant on their case load to assure services are being delivered in accordance with the plan of care. The monthly visit includes reviewing the delivery of services with the participant,

and discussing any questions. If the case managers identify any concerns, including a participant's health and welfare, they are required to address the concerns in a timely manner.

Case managers also complete a quarterly review for each participant that includes a review of incidents that have occurred and identification of any significant changes in health status, to identify trends or areas where further follow-up is needed.

There is a potential to discover possible abuse or neglect throughout all these processes. If this occurs, all providers and provider staff as well as Division staff have the duty to report suspected abuse, neglect, exploitation, self neglect or abandonment, per Wyoming State Statutes, to the Department of Family Services, Protective Services Unit or law enforcement. Wyoming State Medicaid rules also require providers to report serious injuries, injuries due to restraints, police involvement, deaths, and elopements. Incidents are reported to the Department of Family Services, Protective Services Unit, the Division, Protection and Advocacy, Inc., the guardian, the case manager, and law enforcement if applicable.

Providers and provider staff are required to complete training on the Duty to Report and the incident reporting process, to assure incidents are reported in a timely manner. Providers are also expected to document follow-up on incidents that have occurred, and to analyze data and identify trends with incidents.

Effective July 1, 2006, the Division strengthened its review of incident reports to assure that providers were reporting incidents appropriately to all required agencies. The incident reporting form and web-based version were reviewed to assure that the forms include verification of contact information for the DFS. Survey/Certification staff are required to contact the DFS office to verify that a report was received on all incidents reporting suspected abuse, neglect, exploitation, self-neglect, and abandonment. Survey/Certification staff also enhanced the review of participant files during provider recertifications, including review of internal incident reports and staff documentation, for a random sample of participants to determine if incidents occurred that were not reported to the Division and DFS.

All providers must have a complaint process established, and are expected to work with the complainant to address the concerns in a professional manner. If during this process the complainant identifies potential abuse, neglect, exploitation, self-neglect or abandonment, the provider is required to report the incident to the appropriate authorities through the incident reporting process.

The Division also has a formal complaint process set up so a complainant can file a complaint with any Division staff and complaints can be filed anonymously. Information on how to file a complaint is included on the Division's website.

Protection and Advocacy Systems, Inc. completes Participant Rights trainings throughout the state, and includes in this training, the rights of participants to be free from abuse, neglect and exploitation. In addition, Protection and Advocacy Systems, Inc. receives

each incident report and, when appropriate, works with the Division to investigate the incident.

The mortality review process includes a review of all documentation of services for at least a six month period before the death, including a review of all incidents, to determine if there were any suspicions of abuse, neglect, exploitation or abandonment.

The State included its monitoring activities for this assurance as follows:

The Waiver Specialists review the plans of care to assure that they are addressing the health and safety needs of the participants, including the “About Me” section of the plan, which reviews significant events and information from the previous year. Waiver Specialists are also copied on each incident reported to the Division so they can assure that the new plan of care submitted addresses areas of concerns identified in the incidents if appropriate.

Area Resource Specialists attend at least 20% of team meetings and assures that the team reviews incidents and discusses trends or concerns. If there is any indication of possible abuse or neglect the ARS instructs the provider or case manager to file an incident report and complete the appropriate follow-up. This information is also shared with the Survey/Certification Unit, which then requires the provider to submit a quality improvement plan to assure that incidents are not going unreported.

The Survey/Certification Unit of the Division manages the web-based incident reporting process that enables the Division to review incidents within one business day. The Division’s Notification of Incident process includes:

- A web-based system for reporting incidents that includes specific information on the incident, antecedents, actions taken to assure participant’s health and safety, and verification that all required agencies have received the report
- A priority level process that requires Survey/Certification staff to review reported incidents within one business day to determine if an incident requires immediate follow-up (which is considered a level 1 incident)
 - When Level 1 incidents are reported, the Division has a protocol for working with the Department of Family Services, Protective Services Unit and Protection and Advocacy Systems, Inc. to coordinate investigation of the incident and to share pertinent information
- Tracking incidents in the web-based system directs appropriate Division staff to review the status of specific incidents, as well as to run reports on open incidents, incidents by provider, incidents by category etc.
- Substantiation of incidents of suspected abuse, neglect, exploitation or abandonment results in the provider or provider staff being terminated as an employee or provider.

The Survey/Certification Unit manages the Division’s complaint process, and reviews complaints to determine if there is any indication that abuse, neglect, exploitation and/or abandonment is occurring. If this is determined, then the complaint is reported through the Division’s Notification of Incident process so that the Department of Family Services, as well as other appropriate agencies are informed.

The provider recertification process includes review of providers' documentation of services, including internal incident reports, to determine if incidents occurred that were not appropriately reported. If this is found, providers are required to report the incident, and develop and submit a quality improvement plan that addresses this area of non-compliance. The recertification process also includes interviews with providers and provider staff to determine if they are aware of their duty to report incidents.

The recertification process also includes review of a case manager's monthly/quarterly documentation to assure appropriate follow-up is completed on incidents and other health and safety concerns.

The mortality review process includes provider specific recommendations if non-compliance with rules and standards, including the incident reporting requirements, is identified.

If non-compliance with rule, regulation or standard is found through any of these processes the provider is given a recommendation and is required to address the area of concern by submitting a quality improvement plan that includes specific action steps, responsible parties, and due dates. If the recommendation identifies concerns with health and safety, the provider is required to address the significant concerns immediately and submit a quality improvement plan within 15 business days. All other recommendations require a quality improvement plan within 30 calendar days.

The Program Integrity Unit completes monitoring activities to assure the provider is adhering to the quality improvement plan submitted and approved by the Division. Failure to submit an adequate plan or failure to adhere to a plan submitted can ultimately result in sanctions, including civil monetary penalties, suspension of a provider certification, or decertification.

Evidence:

Subassurance: On an on-going basis, the State identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

1. 69 incidents were reported involving participants on the Acquired Brain Injury Waiver.
 - A. 3% (2) incidents were considered priority level 1 and appropriate follow-up was completed.
 - B. Of the eleven categories for reportable incidents, the highest reported category was Police Involvement.
2. 100% of 484 providers certified to provider Acquired Brain Injury Waiver services were recertified during fiscal year 2007. The Division does not currently track recertification recommendations by type of waiver. The following data is from the recertification of all providers certified by the Division.
 - A. 20% of non-CARF providers received at least one recommendation pertaining to incident reporting.

- B. 57% of CARF providers received at least one recommendation pertaining to incident reporting.
 - I. 100% of providers who were not in compliance in this area were required to submit a quality improvement plan.
 - II. The Survey/Certification Unit of the Division completed follow-up monitoring on 100% of these providers to assure that the quality improvement plan was implemented appropriately and the concerns were addressed.
- 3. Area Resource Specialists attended 44% of the team meetings for Acquired Brain Injury Waiver participants and made 1 referral to the Survey/Certification Unit due to non-compliance concerns with Acquired Brain Injury Waiver services.
 - A. An on-site visit was completed and the provider was given a participant specific recommendation.
- 4. The Division received 7 complaints concerning Acquired Brain Injury Waiver services
 - A. None of the 7 complaints involved concerns with health and safety
- 5. 100% (147) of the plans of care were reviewed by the Waiver Specialist who checked the services, supports, behavior plans, and medical information listed to assure the health, welfare, and participant's rights were addressed.
- 6. The Mortality Review process found no concerns identified with potential abuse, neglect, exploitation, or abandonment.

Wyoming Remediation/Action Plans Taken:

As of August 2007, the Division began requiring providers to receive training on incident reporting from the Division when significant concerns with adhering to the incident reporting requirements was found, either through the recertification process, complaint process or incident reporting process. As of January 2008, three trainings have been completed. In addition, the Division has completed a module on incident report training and began distributing the module on DVD March 30, 2008. The Division has also scheduled regional trainings on incident reporting for calendar year 2008.

In January 2006, the Division joined the Statewide Adult Protective Services Team, which includes representatives from stakeholders throughout different agencies. The team was charged with improving education and communication between the various agencies and the DFS, Protective Services Unit, to review current rules and statutes and recommend changes to strengthen DFS authority, and to identify other approaches to assure cases of suspected abuse, neglect and exploitation are reported and investigated. This collaboration has resulted in the following:

- 1. The Team worked with legislators to draft legislation authorizing funding to increase the number of adult protective services personnel throughout the state. The legislation passed, and to date, four additional adult protective service personnel have been hired.
- 2. The Developmental Disabilities Division participated in the initial training of the personnel, giving them more detailed information on the participants served on the waivers, the incident reporting process, and the collaboration that can occur

between the Division and Department of Family Service when incidents are reported.

CMS Recommendations:

1. The State indicated that the Division has a formal complaint process set up so a complainant can file a complaint with any Division staff and complaints can be filed anonymously, and that information on how to file is included on the Division's website. Please submit information on how waiver participants and their family's are informed of this process.
2. The State indicated that Protection and Advocacy Systems, Inc. completes Participant Rights trainings throughout the State. How often are these trainings held?
3. As part of the State's response, please provide additional information in regard to how the State monitors and follows up on the use of medications (including medications used for behavioral purposes), restraints, seclusion and other restrictive measures.
4. Please expand on how the State uses its Division's quality reviews to assure the health and welfare of waiver participants.

State Response:

1. The Division has scheduled regional trainings throughout the state that includes a module on complaints. Flyers were mailed to all guardians and participants, as well as to providers in the regional area. However, we have identified that there is a gap in routinely informing guardians and participants of how to file a complaint. The Division will consider developing a handbook for families and participants.
2. From November 2006 through September 2007, P&A conducted forty-two Rights trainings across the state. Nineteen of these were targeted especially to families and participants who receive waiver services.
3. Medications: The Individual Plan of Care includes information on the medication needs of the participant. During the provider recertification process, the Division reviews a random sample of participants and reviews the implementation of their plan of care, including the monitoring and documentation of medications. However, the Division has identified a gap in this area. Currently the Wyoming Nurse Practice Act does not allow for any delegation of medication administration or monitoring by licensed personnel, such as nurses. Provider staff are trained in monitoring medications and documenting but there is no formal Medication Aide Certification. The Division has developed a task force in conjunction with the Board of Nursing and other key stakeholders to address this gap. The task force is in the process of gathering information on how other states have addressed this issue, and is pursuing some type of medication aide program. The timeline for this project is tentatively set as follows:
 - Compile and review information from other states by September 2008
 - Identify best approach for Wyoming and develop framework for approach by November 2008

- Determine if legislative action is necessary and develop appropriate legislation if needed by December 2008
- If approved by legislation implement program starting July 1, 2009

Other restrictive measures:

The Division promulgated rules in December 2006 that provide clear and comprehensive standards on use of restraints and other restrictive measures. The rules prohibit the use of seclusion. The Division requires that restrictive measures such as restraint usage be ordered by a physician or a qualified behavioral health practitioner, be written in the participant's plan of care, and reviewed and approved by the participant, guardian and Division. The rules also require that the least restrictive measures are attempted first, and that a positive behavior support plan be developed that focuses on positive interventions. The Division monitors compliance with these rules through the provider certification process, incident reporting process, and complaint process. All providers and provider staff who serve participants with restraint usage written in their plan must be certified by a nationally recognized entity in restraint usage, such as MANDT or CPI. The Division sponsored nine regional trainings by a licensed psychologist in the Summer 2008 to provide training to case managers on writing positive behavior support plans.

During the provider certification process, a random sample of participants are chosen to review the implementation of their plans of care. The review includes a provider documentation review, including documentation of restraint usage and other restrictive measures, interviews with participants, families and provider staff on usage of restrictive measures, and review of overall organizational data on use of restraints. The provider's restraint policy is reviewed to assure it meets the standards in the rules.

When restraint usage is reported through incidents or complaints, the Division reviews the participant's plan of care to assure that restraint usage is authorized and that a positive behavior support plan is in place and was followed.

If non-compliance is found through any of these monitoring activities, the provider is required to submit a quality improvement plan.

- For Fiscal Year 2007, 57 providers received recommendations on non-compliance with the rules on restraint or rights restrictions
 - 100% submitted quality improvement plans addressing the recommendations
 - The Survey/Certification unit of the Division completed follow-up monitoring on 100% of these quality improvement plans, and it was determined that the plans were implemented and the areas of non-compliance were addressed.
4. The major focus of the quality reviews completed by the Division is on health, welfare and rights. The quality reviews are centered around the provider recertification process, which covers three main areas:
- Assessing implementation of participants' plans of care, including specific health, welfare and rights concerns identified in the plan, observation of

participants receiving services, interview of staff to assess staff knowledge of participants' needs and plan of care, interviews with participants, family and guardians to assess satisfaction with services and to identify any concerns, and review of participant documentation, including health related documents, staff communication logs, incident reports and other documents to identify specific health, welfare or rights concerns.

- Assessing the physical or environmental components of a provider's services, including inspecting service delivery sites, observing services being delivered to participants during peak times such as mealtimes, positioning times, during behavioral interventions, and at the different service settings, reviewing internal and external building inspections, emergency plans, and review of results of fire and other emergency drills in all service settings.
- Assessing organizational practices of providers, including review of policies and procedures on restraints, incident reporting, emergency drills, complaints, training modules and participant rights, reviewing a sample of staff files to assure staff meet the qualifications for services and have received all the required training, review of data collected on restraint usage, random observations and interviews with participants and provider staff to assess effectiveness of implementation of policies and procedures, review of recommendations made during the previous years Division certification, and review of recommendations made by CARF during the accreditation process that relate to health, safety and rights .

Reviews can also be completed as a result of an incident report or complaint received by the Division. Each incident and complaint is reviewed within one business day to assess the priority level. Incidents or complaints identifying serious concerns with health, safety or rights are "Level Ones" and are reviewed by the Program Integrity Manager and appropriate Waiver Manager to determine next steps, which can include an unannounced on site visit within ten business days. Information on complaints and incidents received for Fiscal Year 2007 are included elsewhere in the evidence report.

During any monitoring activity, the Division has the authority to remove participants from a provider's service if it is determined that the participant is in imminent danger. For Fiscal Year 2007 there was one occurrence of imminent danger identified when the Division received notification that a provider providing residential habilitation services to two participants was going to be arrested on charges of a crime against a person and taken to jail. The Division coordinated with the participants' case managers, and the participants were placed in another service setting that afternoon. The provider was decertified.

As mentioned elsewhere in the evidentiary report, when non-compliance is identified by the Division the provider is required to submit a quality improvement plan to address the non-compliance. For recommendations that relate to health, safety or rights the plan is required to be submitted within 15 business days. The Division completes follow-up monitoring to assure the non-compliance has been adequately addressed.

Final Federal Response:

1. The State's response to this recommendation is acceptable.
2. The State's response to this recommendation is acceptable.
3. CMS appreciates the State's efforts in developing a task force in conjunction with the Board of Nursing and other key stakeholders to address the issue of delegation of medication administration or monitoring by licensed personnel, as well as medication aide certification.
4. The State's response to this recommendation is acceptable.

V. State Medicaid Agency Retains Administrative Authority Over the Waiver Program

The State must demonstrate that it retains administrative authority over the waiver program and that its administration of the waiver program is consistent with its approved waiver application.

Authority: 42 CFR 441.303; 42 CFR 431; SMM 4442.6; SMM 4442.7

CMS Finding: The State substantially met this assurance.

Evidence Supporting Conclusion:

As part of the State's evidence, the assurance and monitoring activities were described as follows:

The waiver is operated by the Developmental Disabilities Division, a separate division within the Single State Agency. Wyoming State Medicaid Agency has ultimate administrative authority and responsibility for the operation of the waiver program. All official correspondence including waiver submission, waiver amendments, and 372 reports are reviewed and signed by the State Medicaid Agency. Although the Developmental Disabilities Division administers the day to day operation of the waiver, any changes are approved by the State Medicaid Agency and the agency is notified of any possible concerns.

All official correspondence including waiver submission, waiver amendments, and 372 reports are reviewed and signed by the State Medicaid Agency. All waiver providers are also Medicaid providers and must meet Medicaid enrollment requirements.

The State Medicaid agency delegates approval of services to the Developmental Disabilities Division. All services must receive a prior authorization number that is assigned through the MMIS. All claims for waiver services are submitted electronically through the MMIS and all providers are paid through that system.

The Division finalized five administrative rules on waiver services in December 2006. These rules are Medicaid rules, and staff from the Medicaid office were included as part

of the stakeholder groups. Medicaid had final approval before these rules were promulgated.

There are additional monitoring activities in which a representative from Medicaid is part of the subcommittee. These include:

- **Extraordinary Care Committee** – a committee that reviews for requests for additional funding based on needs that are not identified in the model that determines the Individual Budget Amount
- **Mortality Review Committee** – a committee that reviews all deaths of waiver participants. Based on this review, both systemic and individual recommendations may be made.

Also, a representative from the Division works with the Medicaid Program Integrity Unit to investigate any irregularities in service or billing.

Evidence:

Subassurance: The Medicaid agency retains ultimate authority and responsibility for the operation of the waiver program by exercising oversight over the performance of waiver functions by other state and local/regional non-State agencies (if appropriate) and contracted entities.

1. Meetings are scheduled as needed.
 - A. The Extraordinary Care Committee meets weekly as needed.
 - B. The Mortality Review Committee meets twice annually.
2. Correspondence has been filed as required by CMS.
 - A. Any concerns have been reviewed by both the Medicaid Agency and the Developmental Disabilities Division

Wyoming Remediation/Action Plan:

Although there have been no trends identified, there has not been a regular meeting or report submitted to the state Medicaid agency on neither activities nor the results of the additional subcommittees. The Developmental Disabilities Division will collaborate with the State Medicaid Office to identify the most efficient vehicle to share information on waiver activities.

The State Medicaid Agency will continue to review and sign all official correspondence to CMS. They will continue all the monitoring activities listed in the monitoring process. Once a meeting or report format has been finalized, it will be reviewed by the State Medicaid Agency.

CMS Recommendations:

In the upcoming renewal, please include the QIS for this waiver via the recommended web-based HCBS application version 3.5. The State is welcome to submit a draft copy of the QIS to CMS before the renewal is due.

State Response:

The State will include the QIS for the upcoming renewal using the recommended web-based HCBS application 3.5. The State will plan on submitting a draft copy of the QIS to CMS before the renewal is due.

Final Federal Response:

The State's response to this recommendation is acceptable.

VI. State Provides Financial Accountability for the Waiver

The State must demonstrate that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.

Authority: 42 CFR 441.302; 42 CFR 441.303; 42 CFR 441.308; 45 CFR 74; SMM 2500; SMM 4442.8; SMM 4442.10

CMS Finding: The State substantially met this assurance.

Evidence Supporting Conclusion:

The State provided the following detail of their financial accountability system:

The waiver uses an Individually Budgeted Amount (IBA) system to allocate resources to individuals based upon need. The Individual Budget Amount Model is named the DOORS (not an acronym) - and was identified by CMS as a Promising Practice in December 2004. Using the Individually Budgeted Amount, the participant and team identifies the services requested for a plan year through development of the annual service plan. Each service request requires review and approval by Division staff.

All services must receive a prior authorization number that is assigned through the MMIS. All billing for waiver services is submitted electronically through MMIS and all providers are paid through that system. There are many edits built into the MMIS that do not allow payment for more units or dollar requests above the amount approved. System edits include service codes with set rates, limits on number of days that can be billed in a month, number of hours that can be billed in a day, and other time specific rules which limit the amount of services that can be billed.

Evidence:

Subassurance: State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

1. In Fiscal year 2007, 100% of waiver services are authorized by a waiver specialist in the Developmental Disabilities Division

2. Numbers are generated through the MMIS that are used to complete the CMS 372 reports. These numbers are double-checked against claims data within the Division to assure accuracy.
3. In Fiscal Year 2007, there were six cases referred to Medicaid Fraud Unit (MFCU) from the Division involving 10 providers. These cases included the following:
 - A. Two cases where case managers allegedly documented that home visits were completed on a monthly basis as required by the rules and billed for services. However, through the complaint process it was alleged that home visits were not being completed and the case managers created documentation. One case resulted in decertification of the case manager and the second case is still pending.
 - B. One provider organization was allegedly instructing staff to create or add to documentation so that it appeared staffing levels were appropriate. The Medicaid Fraud Unit completed their investigation and could not substantiate this case. The Survey/Certification Unit of the Division completed ongoing unannounced visits during a six month period to assure staffing levels were appropriate. No concerns were found.
 - C. A provider providing in-home support services was allegedly billing for times that she was not providing services. Medicaid Fraud completed the investigation and did not substantiate the case.
 - D. A respite provider allegedly billed for services provided before she was added to a participants plan of care, even after being informed that she could not bill for services prior to the plan approval. Medicaid Fraud completed the investigation and did not substantiate the case. The Division worked with the Office of Healthcare Financing (Medicaid) to recover the funds in question and re-educate the provider on the requirements.
 - E. The Division received a complaint that respite providers for a participant were billing for services not provided. The complaint ultimately involved 5 providers and the Medicaid Fraud Control Unit found numerous instances of overlapping billing and inadequate documentation. Although no criminal activity was found, the appropriate providers were required to pay back the funds for services not adequately documented. This was coordinated with the Office of Healthcare Financing. Providers were also educated on documentation standards.

Wyoming Remediation/Action Plan:

Although the financial oversight is very thorough, the Division has realized that within the Individual Budgeted Amount system, there have been negotiated daily rates. The Division has been working with Navigant Consulting, Inc. for the past two years. They have worked first to evaluate the DOORS Individual Budget Amount (IBA) model and second to assist the state in establishing a rate-setting methodology. Through the process of establishing the new rates, three cost studies, a wage survey and supplementary surveys were completed of mostly larger service providers in the state. Also, Navigant and the Division established a service provider working group to guide the rate setting process; this included 4 CARF service providers. This working group had 5 meetings to review the process and provide input. On November 1, 2007 Navigant and the Division held a

meeting with the 20 largest service providers in the State to review the draft rates and provided impact analysis. The service providers had the opportunity to ask questions and provide input. Furthermore, there were 4 select committee meetings in calendar year 2007 in which the rate setting process and concepts were presented and the public, including service providers, families and guardians had the opportunity to comment on the rate setting process.

This standardized and consistently applied rate methodology will go into effect beginning July 1, 2008. This transition will occur over the course of the fiscal year, as each plan of care is renewed. As the new rates are implemented, the Division will monitor the change and effects of the new reimbursement rates.

CMS Recommendations:

1. Please provide the quarter(s) on the CMS-64 report in which the federal share was returned in the case where waiver dollars were recouped, as noted in the evidence section of this assurance.
2. On March 13, 2008, a memorandum dated February 28, 2008 from the Director, Disabled and Elderly Health Programs Group was sent to the State, "CMS 372 Submittal, and the Web-Basing and Process Changes". CMS is eliminating the required "initial" 372 report. Instead of submitting an initial and lag report, CMS will now require one 372 report for each waiver year. This new "annual 372 report" previously known as the "lag" report, will be due to CMS 18 months after the close of the waiver year. This guidance supersedes the State Medical Manual provisions in Section 2700.6 related to the submission of initial 372 reports. The State was also informed that the 372 form is available for use on the web at www.hcbswaivers.net. Please ensure that the lag reports for these waivers are completed and submitted to CMS in the required timeframe.

State Response:

1. Of the six cases referred to Medicaid Fraud Unit (MFCU), five are still in process. An \$80.00 recovery for NOWCAP can be found on 3Q2007 of the CMS-64 report.
2. The State did participate in the training for the "CMS 372 Submittal and Web-Basing and Process Changes." The state will use this format for CMS-372 lag report for Year 3, 2006-2007. This report will be submitted to CMS no later than December 31, 2008.

Final Federal Response:

1. Please keep CMS posted as to the status of which quarter(s) the remaining five cases will be recovered on the CMS-64 report.
2. The State's response to this recommendation is acceptable.